Editorials

Thoughts on Personal Health Maintenance

AS THE coming crunch of not enough dollars for health care begins to hit home for patients and for society alike, it appears certain that more attention will be given to maintaining personal health. This will be in the economic interest of all concerned. Avoiding illness, injury or emotional disturbance has always been the aim of what we have been calling prevention or preventive medicine, but it seems likely that these efforts will be even higher on one's personal or even the national agenda in the quite foreseeable future.

It is relatively easy to list the many things that can and should be done to prevent disease, disability or postpone death, or to improve health so that one simply feels better. Some of the measures are strictly medical such as immunizations against certain diseases; others pertain to public, occupational, environmental or industrial health; still others relate to life-styles or habits such as cigarette smoking, alcohol or other substance abuse, sexual promiscuity or driving unsafely on the streets or highways; and then there are some things persons can do to enhance their own health and well-being—eat wisely, control weight, exercise, rest, relax, avoid stress and so on. If one is already ill, or disabled, or even facing death, there are always other things one can do to avoid further discomfort, disability or unnecessary expense and even to enhance one's well-being under the circumstances.

Advocates of personal health measures or social initiatives for health often seem to assume that everyone wants above all to be healthy and to live a long time, and therefore will logically do everything they can to achieve these objectives. From this assumption it is an easy step to a paternalistic attitude and approach (which young people especially are wont to reject), and then to disillusion and disappointment when large numbers of people and large segments of society simply do not do as health maintenance advocates believe they should, except where legal compulsion has been introduced to make them do so. The reality is that while health may be given lots of lip service, it is probably not as far up on many a personal or social agenda as we would like to think it is.

Part of the problem may be that prevention seems to have something of a negative connotation. If something is prevented, then it doesn't happen and then there is no evidence that anything was accomplished. Personal health maintenance may seem more positive. At least one is doing something that can be seen and understood. But another part of the problem may be much more profound. It is human nature to take chances. It is by taking risks that humans have achieved. It is by no means unusual for persons to risk health, or even life, for some cause they believe to be important, or even just for the thrill of it. This is unlikely to change and, programmed as we are, it probably cannot change. But this very human characteristic can make a mockery of health maintenance and it seldom reckons the cost either in dollars or in health.

Personal health maintenance emerges as a very complex subject. Increasingly there just is not enough money for health care and surely this will give the subject a new importance. But it will not be enough simply to try to prevent specific diseases, injuries or emotional stresses, or even to promote what we believe to be good for health, although all of this is important to do. Just as in good patient care, it will be necessary to work with a whole person and the whole of society if there is to be much or lasting effect. Economic pressure may be one stimulus to do this, but the challenge to physicians and the medical profession to promote personal health maintenance will require our best professional skills and our best efforts. Now the time has come to put it high on our own professional agenda. MSMW

Diagnosing Brain Death

I grew unsure as I did lie
if dead I were or still to die.

SIR CHARLES S. SHERRINGTON, 1906
The Assaying of Brabantius

WHEN THE OUTCOME of modern technologic intensive care is brain death, a physician must consider how long to persist with life-supporting measures. The traditional concept of death based on the close interdependence of function of brain, heart and lungs does not hold when medical technology separates the termination of these functions.

The medical profession as a whole has accepted, in such cases, a brain-centered definition of death. There is general agreement that death of the brain is an appropriate determination of death of a human being and that once this has occurred, further artificial support is fruitless and should be withdrawn. The concept also seems to be accepted by society at large and has been legally sanctioned in many states. For an individual physician, however, the main, immediate problem is whether he or she can accurately distinguish brain dead subjects from other comatose patients who have a chance of even partial recovery.

Pitts in this issue reviews the clinical criteria in use at San Francisco General Hospital Medical Center; several committees have proposed similar criteria.[1] In essence, brain death is present when there is no clinically discernible evidence of any brain function for an extended period, and when the loss of brain function is the result of irreversible structural damage.

The clinical diagnosis of brain death generally is not